



EDS Systems

Claims Administrative Review and Appeals Manual

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Address any comments concerning the contents of this manual to:

EDS Systems Unit
950 North Meridian Street, Suite 1150
Indianapolis, IN 46204
Fax: (317) 488-5169

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Section 1: Introduction

Overview

The Indiana Health Coverage Programs (IHCP) is a Federal-State medical assistance program that provides reimbursement for reasonable and necessary medical care for persons meeting eligibility requirements.

EDS has responsibility for claims processing for the Indiana Family and Social Services Administration (IFSSA). This manual familiarizes enrolled providers with the responsibilities of the Claims Administrative Review and Appeals analyst and serves as a claims administrative and appeals reference guide for IFSSA and EDS internal departments.

A basic overview of the claims administrative review and appeals process is provided in this section. It will be used as an information guide for the Hearings and Appeals analyst as well as other EDS internal departments such as Provider Assistance, Written Correspondence, Surveillance and Utilization Review, Inspection of Care, and the Prior Authorization Unit HealthCare Excel.

Providers will be able to review the claims administrative review and appeals policy and procedures; the administrative code as it pertains to claims reimbursement, claims administrative review processing procedures; and claims administrative review/appeals reports and forms generated from or used by the department.

Claims Administrative Review Policy

If a provider disagrees with the IHCP determination of payment, the provider's right of recourse limited to an administrative review and appeal as provided in *405 IAC 1-1-3* as stated below.

Filing of Claims for Reimbursement: *405 IAC 1-1-3*

All provider claims for payment for services rendered to members must be originally filed with the Medicaid contractor within 12 months of the date of the provision of the service. *405 IAC 5-3-9* provides conditions for retro approval thus allowing for payment beyond the 12 month from date of services. A Medicaid provider who is dissatisfied

with the amount of the reimbursement may appeal under the provisions of 470 IAC 1-4. However, prior to filing such an appeal, the provider must either:

- Resubmit the claim if the reason for denial of payment was due to incorrect or inaccurate billing by the provider;
- Submit, if appropriate, an adjustment request to the EDS Adjustment Unit; or
- Submit a written request to EDS, stating why the provider disagrees with the denial or amount of reimbursement.

All requests for payment adjustments and reconsideration of claims that have been denied must be submitted to EDS within one year of the date of notification that the claim was processed. In order to be considered for payment, each subsequent claim resubmission or adjustment request must be submitted within one year of the most recent notification that the claim was processed. The date of notification shall be considered to be three business days following the date of the remittance advice on which the claim appears.

Steps Taken Prior to the Administrative Review Process

Prior to filing a claims administrative review, the provider must exhaust routine measures to obtain payment before filing an administrative review request. The following information is the administrative review process in practical terms.

- Upon receipt of the claim denial, the provider must review the denial, make applicable corrections and resubmit the claim via routine claim-processing channels.
- If the claim paid, and the provider disagrees with the reimbursement, the provider must submit an adjustment request with documentation stating why they disagree with the reimbursement.
- If the provider received the same results following the two previous initial administrative review steps, the next action is to file for an administrative review.

Filing Administrative Review

- Complete an Indiana IHCP Inquiry stating the disagreement with the denial or amount of reimbursement. Indicate *Administrative Review* clearly on the form, and attach all pertinent documentation.

- Send the package of information to:

**EDS
Claims Administrative Review
Written Correspondence
P.O. Box 7263
Indianapolis, IN 46207-7263**

The EDS administrative review analyst responds in writing within 90 working, days.

Inquiry Versus Administrative Review Criteria

Upon receipt of a request for claims administrative review, a written correspondence analyst reviews the request and determines whether the issue is routine or complex. If the situation is a routine question or problem, the analyst answers the administrative review request.

If the issue is complicated or involved and it is obvious that the provider has made numerous attempts to solve the problem, the analyst refers the inquiry to either the written correspondence supervisor or to a field consultant for review.

Listed below are examples of routine inquiries that are forwarded to the administrative review department:

- Requests for manuals
- Requests for duplicate Explanation of Payment listings
- Requests for forms
- Claim status
- Claim denials relating to eligibility
 - Spenddown
 - QMB
 - All other restrictions
- Claim reimbursement and adjustments:
 - Routine claim payments such as hospital reimbursements, max pricing, and credits
 - Medicare crossover adjustments
- Routine claim denials
 - Any EOP denial
- Services requiring prior authorization
 - Reference Covered Services and Limitations

- Medicaid bulletin updates
- Services not requiring prior authorization:
 - Reference covered services and limitations
 - Medicaid bulletin updates
- Third party liability
 - Primary insurance carriers
 - Medicare coverage
- Medical service limitations on the following:
 - Chiropractor
 - Transportation
 - Mental health
 - Dental
 - Nursing and therapy
 - Physician
- Billing procedures for all provider types and specialties

Complex Issues Forwarded to Administrative Review

Once the written correspondence supervisor, field representatives, or Manager confirm that the issue warrants an administrative review, then the request is forwarded to the Hearings and Appeals department for processing.

Other Administrative Reviews/Appeals

Appeals pertaining to restricted card, provider recoupment, and DRG reimbursement are handled by the Surveillance and Utilization Department at Health Care Excel.

These types of reviews must be mailed to the following address:

HCE
Surveillance and Utilization Review
P.O. Box 531700
Indianapolis, IN 46253-1700

Persuant to 405 IAC 5-1-6, requests for review pertaining to the coverage of a particular service or supply must be mailed to the Medical Policy Department of Health Care Excel. Please include all pertinent information with the request and mail to the following address:

HCE
Medical Policy
P.O. Box 53380
Indianapolis, IN 46253

The requesting provider is notified of the receipt of the request and of the outcome of the review. Due to the complexity of reviewing for coverage, there is no limitation on the response time.

Claims Administrative Review Procedures

The purpose of this section is to document department procedures that ensure the claims administrative reviews are handled in an effective and timely manner. The following procedures are included in this section:

- Logging all administrative reviews and appeals.
- Claims administrative review processing procedures
- Return-to-provider procedures
- Administrative review pending procedures
- Reference tools used by the analyst
- Administrative review responses

Logging

Upon receipt of the claim administrative review (CAR) from the inquiry supervisor, field consultant, an EDS manager, or the Indiana Family and Social Services Administration (IFSSA), the review is logged by the Hearings and Appeals clerical staff and then forwarded to the claims review analyst. Claim appeals come directly from the

Indiana Family and Social Services Administration. The logging procedures are as follows:

The clerk assigns a control number to each administrative request. The control number consists of the following elements: YR - JJJ - TOA - SS.

- YR – A two digit year abbreviation. For Example 1994 is typed 94
- JJJ – The Julian day of the year
- TOA – The Type of Action code identifies the type of request received by the department. The TOA codes are defined below:
 - A = Appeal. All administrative claim appeals have the *A* code in the control number.
 - R = Review. All administrative claim reviews have the *R* code in the control number.
 - H = Hearing. All administrative claim appeals that went to hearings are recoded with the *H* in the code field. When a Hearing Decision (reference Section 4) is made by the Administrative Law Judge or other authority, EDS is notified and must comply with the decision whether favorable or unfavorable.
 - J = Judicial Review. All claim hearings that were forwarded to Judicial Review are recoded with the *J* in the code field.
 - D = Dismissed. All claim appeals or hearings that are dismissed are recoded with the *D* in the code field. A dismissal letter (reference Section 4) is sent to the provider and a copy is sent to EDS from the OMPP legal section. It is a notification that EDS, provider, or member has rescinded the action.
 - W = Withdrawn. All claim reviews, hearings, and appeals that are withdrawn by the appellant are recoded with a *W* in the code field.
- SS – The sequence number. Each administrative request is assigned a unique sequence number. The SS range is 0000 thru 9999.

Once the administrative review has been assigned a control number, the review is logged and the following information is indicated on the log.

- Member name
- Provider number and name, if applicable
- Date(s) of service
- Type of request, administrative review or appeal
- A narrative about the review request in 30 characters or less

- Required of response, 90 Days from date of receipt
- Place review contents in a file folder
- Note member name on file folder
- Transfer file to the claims administrative review analyst

Claims Administrative Review Processing Procedures

Upon receipt of the review or appeal, the analyst completes all of the functions indicated below to adjudicate the claim administrative review:

- Analyze documentation.
- Complete the Claims Administrative Review Acknowledgement of Receipt Letter and send it to the provider. (Reference Section 4, Forms)
- Confirm member eligibility.
- Confirm timeliness
- Contact the provider to clarify all issues, if necessary.
- Determine claim disposition.
- Determine the problem.
- Clarify issues of claims and adjustments resubmitted due to administrative errors.
- Follow-up on pending reviews weekly.
- Notify applicable parties of disposition in writing within 90 working days.
- Review Requests awaiting additional information from the provider or member remain pending until receipt of requested information.
- Research history.
- Retain all supporting documentation in administrative review file folder.
- Review medicaid policy regarding issue(s) being reviewed.

If the member was not eligible and the service appears to be appropriate, complete the RTP form and return the entire file to the provider with instructions to contact the member's caseworker for follow-up on the member's IHCP eligibility

If the member is not on the system and the service appears to be inappropriate, send a notification to the provider that the member is no longer eligible and that the documentation submitted with the request does not support the administrative review request.

Once a claims administrative review determination has been made, the claims administrative review decision is completed and mailed to the provider

Return-To-Provider Procedures

The return-to-provider (RTP) form is used to:

- Request additional information
- Return original documents
- Notify providers that the IHCP member was not eligible
- Return all non-administrative reviews

The provider submits all documentation that supports attempts to resolve the claim issue(s) prior to requesting an administrative review. All documentation submitted with the request must comply with the *405 IAC 1-1-3, Claims Past the Filing Limit*.

Once it has been determined that a RTP form is necessary, the procedure outlined below is used when the information submitted by the provider is either vague or missing. An RTP form is completed and sent to the provider requesting additional documentation.

- A copy of the RTP form is incorporated into the file and pended for 30 working days.
- If the provider does not return the requested information within the 30 working days, the administrative review is discontinued and the provider is notified in writing.
- The notification letter is incorporated in the file.

Pending Procedures

This procedure is used to process all claim administrative reviews that are pended for additional information. Please refer to the RTP Procedures for RTP reasons. Claim Administrative Review requests that are received by EDS with incomplete information, such as the claim request is missing the member name and IHCP number, are pended for additional information needed in order to identify the claim

in question. Examples of pend reasons include but are not limited to the following:

- Awaiting additional information such as an itemization of charges
- Awaiting an explanation of benefits from a primary carrier
- Awaiting an explanation of Medicare benefits from the provider, the provider's agent (attorney), the member or the member's representative.

Since the deadline date to return requested information is 30 working days, the following pend procedures are used.

- Complete an RTP form to request the needed information.
- Copy the RTP form for the file.
- Indicate on the file folder what information has been requested from the provider.
- Indicate the date the request was mailed.
- Note the follow up date for the request that is 15 days from the mailed date.
- On the follow up date, contact the provider to check the status of request.
- If the provider does not return the requested information within 30 days, the administrative review analyst contacts the provider by telephone to have the information faxed or the analyst sends a second request notice indicating when the information was requested and that the information must be received by EDS by the 30th working day. The analyst also informs the provider that if the information is not returned within the 30 working days, the administrative review is discontinued.
- If the analyst is notified by the provider of a delay in obtaining the requested information, the analyst documents the conversation and sends a second request notice allowing the provider another 30 working days to obtain the information.
- If there is no response from the provider on the 60th day, the claims administrative review is discontinued and the provider is notified in writing.
- The RTP form and a copy of the discontinuance letter is incorporated into the file and the file is closed.

When a claims administrative review is discontinued, the provider may choose to send another administrative review. The review is processed as a new request and the provider is notified of the

disposition within 90 working days from the date of receipt of the new request.

Reference Tools

The claim administrative reviews are researched thoroughly and review decisions must be supported with documentation.

In order to be proficient on administrative review and appeal responses, it is imperative that the analyst have up-to-date information references. The reference tools available to the analyst include the following:

- Online history files
- Hard copy reference files
- Reference reports
- Various external source documents – Listed below are the current reference materials used to process both administrative reviews and appeals.

Online History Files

The online history files are subsystems in IndianaAIM Production. These files include the following:

- Claims history files
- Prior authorization files
- Procedure code and diagnostic code reference files
- Provider maintenance files
- Member maintenance files
- Third party liability files

Hard Copy Reference Files

The hard-copy reference files contains the following books and manuals:

- Claims Resolution Manual
- Covered Services and Limitations
- Current Procedural Terminology
- ICD-9-CM Diagnosis Manual

- Current Procedural Terminology (CPT)
- Federal Register
- Indiana Administrative Code References
- Indiana Health Coverage Programs Provider Manual
- Health Coverage Programs Claims Processing Manual
- Health Coverage Programs Provider Bulletins
- Medicare Claims Processing Manual
- Microfiche Claim Details
- Microfiche Provider EOPs
- Microfiche Member Eligibility
- Prior Authorization Manual
- Indiana State Plan Manual
- Teleprocessing User's Guide

Reference Reports

The following reference reports are obtained from Adhoc Reports:

- Explanation of Payment Listing Report
- Level 8 Report
- Max Fee Report
- PAS Report

Other Documents

There are other miscellaneous documents used as reference tools.

- Explanation of payment listings from the provider
- Internal memorandums
- Previous provider inquiry responses
- Provider letters
- State letters
- Various forms such as Spenddown, C519 Form, Explanation of Medicare Benefits, and Coordination of Benefit forms.

Special Information

If the analyst received an administrative request and the eligibility file no longer exists, policy will be addressed.

Administrative Review Responses

The administrative review analyst responds to all administrative reviews regardless of the review disposition within 90 working days from the receipt of the administrative request.

Each denial decision is specific, detailed, and fully documented.

Providers should not refile a previously submitted administrative review request that EDS has acted upon.

If the administrative review response is an unfavorable response to the provider, EDS will state the appeal rights and the time period during which appeal rights may be exercised.

Section 2: Claims Administrative Appeals

Overview

This section is used as a quick reference when looking up or reviewing claims reimbursement administrative code *470 IAC 1-4* as it relates to the Purpose, Application of parties, Filing an Appeal, and Appeal Case Process.

Claim appeals must be filed within 15 days in accordance with *IAC 4-21.5-3-7* Hearings and Appeals.

Claims Administrative Appeals: 470 IAC 1-4

When, pursuant to *405 IAC 1-1-3*, all procedures required for administrative review prior to the filing of an appeal have been exhausted, a provider can send a request for appeal to the following address:

**Family and Social Services Administration
Appeals and Hearings Section
402 West Washington Street, Room W392 Legal Section
Indianapolis, IN 46204**

Purpose – Construction of Rule: 470 IAC 1-4-1

Sec.1(a): It is the purpose of *470 IAC 1-4* to establish a uniform method of administrative adjudication within the Indiana state department of public welfare in order to determine whether any departmental action complained of was done in accordance with the federal and/or state laws.

Sec.1(b): *470 IAC 1-4* shall be construed in such a manner as to provide all parties with an adequate opportunity to be heard and all grievances to be administratively adjudicated in accordance with due process of law.

Sec. 1(c): In the event that any provision of *470 IAC 1-4* is deemed to be in conflict with any other provision of any federal or state statute and/or regulation which is specifically applicable to any welfare program being appealed hereunder, then such other statute or

regulation shall supersede that part of *470 IAC 1-4* in which the conflict is found.

Application of Parties: 470 IAC 1-4-2

Sec. 2(a): Application. In the event that the rights, duties, obligations, privileges and/or other legal relations of any person or entity, which are required or authorized by law to be determined by the Indiana state department of public welfare, or any county department of public welfare, then such person or entity may request, as provided for in *470 IAC 1-4-3*, an administrative hearing pursuant to *470 IAC 1-4*.

Sec. 2(b): Standing. Unless otherwise provided for by law, only those persons or entities, or their respective attorneys at law, whose rights, duties, obligations, privileges and/or other legal relations are alleged to have been adversely affected by any action or determination by the state department or any county department, may request an administrative hearing pursuant to *470 IAC 1-4*. Any alleged harm to an appellant must be direct and immediate to the appealing parties and not indirect and general in character.

Sec. 2(c): Parties. The parties to any administrative adjudication held pursuant to *470 IAC 1-4* shall include the following:

1. The person(s) or entity(ies) so requesting the hearing who shall be known as the "appellant".
2. The state or county welfare department.

Filing an Appeal: 470 IAC 1-4-3

Sec. 3(a): Any party complaining of any state or county department action in accordance with *470 IAC 1-4*, may file a request for an administrative hearing as provided below.

Sec. 3(b): Member Appeals. Unless otherwise provided for by statute or regulation, appeal requests by members or applicants shall be filed in writing with the county or state department of public welfare not later than thirty (30) days following the effective date of the action being appealed and the hearing shall thereafter be scheduled in the county where the appellant resides.

Sec. 3(c): Provider and Licensee Appeals. Unless otherwise provided for by statute or regulations, appeal requests by providers, licensees or prospective licensees shall:

1. Be filed in writing by the aggrieved party or its attorneys at law;
2. Set out each objection to the department's actions as well as cite the legal reasons therefore [*sic*]; and
3. Be delivered to the state department of public welfare (15) days after receipt of the initial notice upon which the appeal is premised.

Failure to state objections and the legal reasons therefore [*sic*], in a timely manner, shall be deemed a waiver of such objections.

Sec. 3(e): Any party filing an appeal under *470 IAC 1-4* is not excused from exhausting all interim procedures that may be required for administrative review prior to the filing of his appeal. Any issues not preserved in a timely manner within said interim review procedures shall not be an issue during the evidentiary hearing inasmuch as the same shall be deemed to have been waived.

Sec. 3(f): Appointment of Administrative Law Judge (ALJ). The administrator shall appoint an administrative law judge who shall schedule the matter for an evidentiary hearing and who shall issue all notice to the parties regarding the time and place of such hearing.

Note: The IFSSA have ALJs on staff.

Ellen Fujawn is an attorney under contract with IFSSA, in the Hearings and Appeals, Legal Department, who generally hears all provider administrative hearings.

Appealed Case Process

Once a case is appealed, the hearing must be scheduled with an administrative law judge and set for hearing by the Office of Medicaid Policy and Planning (OMPP) legal staff. All hearings are held in the county of residence.

Upon receipt of an appeal request by IFSSA, the OMPP legal staff notifies EDS of the Hearing and provides the following information:

- Member or provider who requested an appeal
- Dates of service
- Scheduled hearing date

Upon receipt of the hearing notice from the OMPP, EDS performs the following tasks:

- Review the administrative review response

- Complete additional research if necessary
- Prepare appeal package for court which contains all support documentation on the administrative review response
- Meet with the OMPP legal staff to review evidence prior to the hearing as necessary

Section 3: Claims Administrative Review and Appeal Reports and Forms

This section contains all reports and forms that used by or generated from the Claims Administrative Review and Appeals Department.

Sample reports are being developed and when complete, placed in the manual.

The return-to provider (RTP) notice is currently the only form used by the department when requesting additional information from or returning information to the provider. The RTP form elements are listed on the following page followed by the RTP form.

Return-To Provider Form Elements

This form is used to either request additional information, to return all documents when an IHCP member is no longer on the eligibility file, and to return all non-administrative reviews.

The RTP form includes the following:

- Provider name
- Provider address
- Provider number
- Member name
- Members IHCP ID Number
- Date of request
- Type of request, reference RTP form (1 thru 9)
- Return notice to address

**EDS - Indiana Medicaid
Hearings & Appeals Dept.
P.O. Box 68763
Indianapolis, IN 46268-0763
Return-To Provider
Notice**

Provider Name: _____ Provider Addr: _____ City, State, Zip: _____	Recipient's Name: _____ Recipient's Medicaid #: _____ Date of Service(s): _____
--	--

We are unable to process your request for a Claims Administrative Review because information is either missing or the request does not qualify as an administrative review. Please submit your request to the following address. Otherwise, Please return with this document the requested items.

- _____ 1. Recipient Name/or IMedicaid ID Number.
- _____ 2. Please submit a copy of the Medicare payment listing and/or EOMB with your claim.
- _____ 3. Provide and Explanation of Benefits from other insurance carrier.
- _____ 4. Please indicate the provider number. _____
- _____ 5. Please send a copy of the prior authorization form.
- _____ 6. Please send your request to: Provider Inquiry, P.O. Box 68420, Indpls, IN 46268.
- _____ 7. Please send your request to: Claim Adjustments, P.O. Box 68765, Indpls, IN 46268.
- _____ 8. Please send your request to: Claims Past Filing Limit, P.O. Box 68924, Indpls, IN 46268.
- _____ 9. Your Claim(s) have been forwarded to: _____

- _____ 10. There is not record of a claim filed to Medicaid by your entity.
- _____ 11. This recipient is no longer on the eligibility file. Please contact the recipient's caseworker. Once the file has been recreated or reloaded, please resubmit your Claims Administrative Review.
- _____ 12. Other _____

Date: _____
Victoria Burks, H&A Claims Administrative Review Analyst

Figure 3.1 – Return-To Provider Notice

Claims Administrative Review Form

This form is sent to providers subsequent to an administrative review disposition. It is not be used for claim appeals. The form has all the pertinent information necessary to clearly identify the provider, member, date(s) of service, and claim administrative review resolution. The form is located on the following page and the form elements are indicated below:

Date administrative received; Provider Name; Provider Address; Provider City, State, ZIP; Provider Number; Date of Service; Prior Authorization Number, if applicable; Members Name, IHCP RID#; Claim Control Number; Claim Amount Submitted; Administrative Review Disposition Date; and the Administrative Review Deposition.

EDS - INDIANA HEALTH COVERAGE PROGRAMS
CLAIM ADMINISTRATIVE REVIEW FORM
950 N. MERIDIAN STREET, 10FL
INDIANAPOLIS, IN 46204

Date Received: _____	Member Name: _____
Provider Name: _____	Medicaid PCN/RID: _____
Provider Address: _____	Date of Service: _____
City, St, Zip: _____	Prior Auth. Number: _____
Provider Number: _____	Claim Number: _____
Adm Review Disposition _____	
Date: _____	
Adm Review Decision: _____	Amount Submitted: _____

Dear Provider:

This letter is in response to your request for an Administrative Review of the claim reimbursement/adjustment/denial made by our staff for the above member.

After careful review, it was concluded that the above indicated claim was denied/paid/adjusted correctly/incorrectly/in error. Following is an explanation of the claims disposition.

Cite: _____

Reason: _____

If you disagree with this decision you have the right to appeal under IC 4-21.5-3. A request for an appeal must be made by the Health Coverage Programs provider in a writing that states the reason for appeal. This request should also include the member's name and IHCP number, a copy of the original claim and all denial notices. Your request for appeal must be received within fifteen (15) days of your receipt of this letter. Please send this information to the following address:

Family and Social Services Administration
Office of the General Counsel
402 W. Washington Street, Room W451
Indianapolis, IN 46204
Attn: Medicaid Appeals

Sincerely,

Victoria A. Burks
Administrative Review, Hearings and Appeals

Figure 3.2 — Claim Administrative Review Form

Administrative Review Acknowledgement Letter

This letter is used to notify the provider that EDS has received the request for a claims administrative review. Upon receipt of the review request from the provider, the analyst fills in the elements on the letter and mails the letter(s) on the same day.

The letter elements that are completed by the analyst are listed below:

Date request was received; Providers name; Providers address;
Provider city, State, ZIP; Provider number, Members Name, Members
IHCP identification number and signature of the analyst.

On the following page is the acknowledgement letter that is sent to the provider.

**EDS Hearings and Appeals Dept.
Claims Administrative Review
950 North Meridian Street, 10 FL.
Indianapolis, IN 46268**

Date:

Provider Name
Provider Address
Provider City, State, Zip
Provider Number

Re: Acknowledgement of Receipt Letter

Member Name: _____
Member ID#: _____
Date(s) of Service: _____

This letter is to confirm that we have received your request for a claims administrative review for the above indicated member.

We are currently processing your request. Please allow approximately 90 working days for a disposition.

Sincerely,

Administrative Review Analyst
Hearings and Appeals

Figure 3.3 – Acknowledgement of Receipt Letter

Glossary

This glossary defines the universal terms of the Indiana Title XIX program as presented in the Request for Proposals (RFP). The spelling and capitalization is approved by the Office of Medicaid Policy and Planning (OMPP) for use in all documents. Any changes made to the original RFP glossary were made at the request of the OMPP. The terms and definitions in the Indiana Title XIX Common Glossary cannot be changed without contacting the Publications Manager of the Documentation Management Unit who will obtain confirmation and approval from the OMPP. Individual units should include additional terms, as required, in the glossary of their documents.

590 Program	A state of Indiana medical assistance program for institutionalized persons under the jurisdiction of the Department of Corrections, Division of Mental Health, and Department of Health.
auto assignment	IndianaAIM process that automatically assigns a managed care recipient to a managed care provider if the recipient does not select a provider within a specified time frame.
bill	Refers to a bill for medical services, the submitted claim document, or the electronic media claims (EMC) record. A bill may request payment for one or more performed services.
buy-in	A procedure whereby the State pays a monthly premium to the Social Security Administration on behalf of eligible medical assistance recipients, enrolling them in Medicare Part A or Part B or both programs.
CCF	Claim correction form. A CCF is generated by IndianaAIM and sent to the provider who submitted the claim. The CCF requests the provider to correct selected information and return the CCF with the additional or corrected information.
CCN	Cash control number. A financial control number assigned to identify individual transactions.
claim	A provider's request for reimbursement of Medicaid-covered services. Claims are submitted to the State's claims processing contractor using standardized claim forms: HCFA-1500, UB-92, ADA Dental Form, and State-approved pharmacy claim forms.
contractor, contractors, or the contractor	Refers to all successful bidders for the services defined in any contract.

core contractor	The successful bidder on <i>Service Package #1: Claims Processing and Related Services</i> .
core services	Refers to <i>Service Package #1: Claims Processing and Related Services</i> .
county office	County offices of the Division of Family and Children. Offices responsible for determining eligibility for Medicaid using the Indiana Client Eligibility System (ICES).
covered service	Mandatory medical services required by HCFA and optional medical services approved by the State. Enrolled providers are reimbursed for these services provided to eligible Medicaid recipients.
customer	Individuals or entities that receive services or interact with the contractor supporting the Medicaid program, including State staff, recipients, and Medicaid providers (managed care PMPs, managed care organizations, and waiver providers).
DHHS	U.S. Department of Health and Human Services. DHHS is responsible for the administration of Medicaid at the federal level through the Health Care Financing Administration.
EOB	Explanation of benefits. An explanation of claim denial or reduced payment included on the provider's remittance advice.
EOMB	Explanation of Medicare benefits. A form provided by IndianaAIM and sent to recipients. The EOMB details the payment or denial of claims submitted by providers for services provided to recipients.
EOP	Explanation of payment. Describes the reimbursement activity on the provider's remittance advice (RA).
FFP	Federal financial participation. The federal government reimburses the State for a portion of the Medicaid administrative costs and expenditures for covered medical services.
fiscal year - Indiana	July 1 - June 30.
fiscal year - federal	October 1 - September 30.
FSSA	Family and Social Services Administration. The Office of Medicaid Policy and Planning (OMPP) is a part of FSSA. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs. However, the OMPP is designated as the single State agency responsible for administering the Indiana Medicaid program.

HCFA	Health Care Financing Administration. The federal agency in the Department of Health and Human Services that oversees the Medicaid and Medicare programs.
HCFA-1500	HCFA-approved standardized claim form used to bill professional services.
HCPCS	HCFA Common Procedure Coding System. A uniform health care procedural coding system approved for use by HCFA. HCPCS includes all subsequent editions and revisions.
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification. ICD-9-CM codes are standardized diagnosis codes used on claims submitted by providers.
ICN	Internal control number. Number assigned to claims, attachments, or adjustments received in the fiscal agent contractor's mailroom.
IDOA	Indiana Department of Administration. Conducts State financial operations including: purchasing, financial management, claims management, quality assurance, payroll for State staff, institutional finance, and general services such as leasing and human resources.
IMD	Institutions for mental disease.
IndianaAIM	Indiana Advanced Information Management system. The State's current Medicaid Management Information System (MMIS).
IOC	Inspection of care. A core contract function reviewing the care of residents in psychiatric hospitals and ICFs/MR. The review process serves as a mechanism to ensure the health and welfare of institutionalized residents.
ISMA	Indiana State Medical Association.
LOC	Level-of-care. Medical LOC review determinations are rendered by OMPP staff for purposes of determining nursing home reimbursement.
lock-in	Restriction of a recipient to particular providers, determined as necessary by the State.
LTC	Long-term care. Used to describe facilities that supply long-term residential care to recipients.
Medicaid fiscal agent	Contractor that provides the full range of services supporting the business functions included in the core and non-core service packages.

medical policy contractor	Successful bidder on <i>Service Package #2: Medical Policy and Review Services</i> .
non-core services	Refers to <i>Service Packages #2 and #3</i> .
non-core contractors	Refers to the Medical Policy Contractor and the TPL/Drug Rebate Contractor.
OMPP	Office of Medicaid Policy and Planning.
PA	Prior authorization. Some designated Medicaid services require providers to request approval of certain types or amounts of services from the State before providing those services. The Medical Services Contractor and/or State medical consultants review PAs for medical necessity, reasonableness, and other criteria.
PMP	Primary medical provider. A physician who approves and manages the care and medical services provided to Medicaid recipients assigned to the PMP's care.
QDWI	Qualified disabled working individual. A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Medicaid benefits cover payment of the Medicare Part A premium only.
QMB	Qualified Medicare beneficiary. A federal category of Medicaid eligibility for aged, blind, or disabled individuals entitled to Medicare Part A whose incomes are less than 100 percent of the federal poverty level and assets less than twice the SSI asset limit. Medicaid benefits include payment of Medicare premiums, coinsurance, and deductibles only.
RA	Remittance advice. A summary of payments produced by IndianaAIM explaining the provider reimbursement. RAs are sent to providers along with checks or EFT records.
RBRVS	Resource-based relative value scale. A reimbursement method used to calculate payment for physician, dentists, and other practitioners.
shadow claims	Reports of individual patient encounters with a managed care organization's (MCO's) health care delivery system. Although MCOs are reimbursed on a per capita basis, these claims from MCOs contain fee-for-service equivalent detail regarding procedures, diagnoses, place of service, billed amounts, and the rendering or billing providers.

SLMB	Specified low-income Medicare beneficiary. A federal category defining Medicaid eligibility for aged, blind, or disabled individuals with incomes between 100 percent and 120 percent of the federal poverty level and assets less than twice the SSI asset level. Medicaid benefits include payment of the Medicare Part B premium only.
SSA	Social Security Administration of the federal government.
SSI	Supplementary Security Income. A federal supplemental security program providing cash assistance to low-income aged, blind, and disabled persons.
specialty vendors	Provide support to Medicaid business functions but the vendors are not currently Medicaid fiscal agents.
State	Spelled as shown, State refers to the State of Indiana and any of its departments or agencies.
subcontractor	Any person or firm undertaking a part of the work defined under the terms of a contract, by virtue of an agreement with the prime contractor. Before the subcontractor begins, the prime contractor must receive the written consent and approval of the State.
SUR	<p>Surveillance and Utilization Review. Refers to system functions and activities mandated by the Health Care Financing Administration (HCFA) that are necessary to maintain complete and continuous compliance with HCFA regulatory requirements for SUR including the following SPR requirements:</p> <ol style="list-style-type: none">1. statistical analysis2. exception processing3. provider and recipient profiles4. retrospective detection of claims processing edit/audit failures/errors5. retrospective detection of payments and/or utilization inconsistent with State or federal program policies and/or medical necessity standards6. retrospective detection of fraud and abuse by providers or recipients7. sophisticated data and claim analysis including sampling and reporting8. general access and processing features9. general reports and output

systems analyst/engineer	Responsible for performing the following activities: 10. Detailed system/program design 11. System/program development 12. Maintenance and modification analysis/resolution 13. User needs analysis 14. User training support 15. Development of personal Medicaid program knowledge
TPL	Third Party Liability.
TPL/Drug Rebate Services	Refers to <i>Service Package #3: Third-Party Liability and Drug Rebate Services</i> .
UB-92	Standard claim form used to bill hospital inpatient and outpatient, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), and hospice services.
UCC	Usual and customary charge.
UPC	Universal product code. Codes contained on the first data bank tape update and/or applied to products such as drugs and other pharmaceutical products.
UPIN	Universal provider identification number.
WIC	Women, Infants, and Children program. A federal program administered by the Indiana Department of Health that provides nutritional supplements to low-income pregnant or breast-feeding women, and to infants and children under 5 years of age.

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